Washington State Health Care Authority
Public Employees Benefits Board

Student Certification/Change

To qualify for PEBB coverage, your student dependent must be:

- Age 20 through 23.
- Registered and attending classes at an accredited secondary school, college, university, vocational school, or school of nursing.

Dependent student eligibility:

- Begins the first day of the month of the quarter or semester the student is enrolled and attending classes.
- Ends the last day of the month the student attends school or of the quarter or semester, whichever comes first.
- Continues year-round for students who attend three of the four school quarters or two semesters.
- Continues for up to three months after graduation if (1) you are covered at the same time; (2) the dependent has not reached age 24; and (3) the dependent meets all other eligibility requirements under WAC 182-12-260(4).
- Includes married children who qualify as your dependent under Internal Revenue Code (WAC 182-12-260[3]).

Instructions

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- If you are enrolling your dependent as a student for the first time, or re-enrolling a student dependent, please submit this form **30 days before** your dependent returns to school.
- You must mail or hand-deliver this form if you want to terminate coverage for your dependent.
- If you terminate your dependent's coverage due to a qualifying event (for example, he or she loses dependent status), you must notify PEBB Benefit Services in writing within **60 days** of the event. If you don't, your dependent will lose his or her right to extend PEBB coverage.
- Notify PEBB Benefit Services if your student's status changes. If you have questions, call us at 1-800-200-1004.
- Report address corrections to your personnel, payroll, or benefits office (if you are an employee) or to PEBB Benefit Services (all other members).
- **You must sign and date this form.**

SECTION 1: Subscriber Information	
Name	Social security number
Address	Phone Work Home

SECTION 2: Dependent Information *List only one dependent per form.*	
Dependent name	Social security number
Address (if different from subscriber, please notify your personnel or payroll office)	Date of birth
Is this dependent married? ☐ Yes ☐ No If yes, date of marriage _____ If yes, does this dependent qualify as your dependent under the Internal Revenue Code? ☐ Yes ☐ No	

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SECTION 3: Enrollment Information

Full school name | City, State | Registrar's phone

Is your student dependent currently enrolled in school? ☐ Yes ☐ No Last quarter/semester attended (month/year) _____

Expected school attendance for the 12 months following current enrollment

QUARTER ☐ Fall Month/Year _____ ☐ Winter Month/Year _____ ☐ Spring Month/Year _____ ☐ Summer Month/Year _____

SEMESTER ☐ Fall Month/Year _____ ☐ Spring Month/Year _____ ☐ Summer Month/Year _____ Other _____

Expected graduation date (Month/year) _____

Note: Your dependent will be certified only for the attendance checked above. See eligibility requirements on the front of this form for details.

SECTION 4: Notice of Qualifying Event/Request to Terminate Dependent's Coverage

Complete only if your dependent is no longer eligible for PEBB coverage, based on eligibility rules on the front of this form. You must notify us in writing within **60 days** after a qualifying event (such as a dependent's loss of dependent status). If you don't, your dependent will lose the right to elect COBRA or other continuation coverage.

When you notify us about your dependent's loss of dependent status (and when we request it), you must provide satisfactory documentation of the qualifying event (for example, a marriage certificate showing the date the dependent married or a transcript or other satisfactory evidence showing the last date of student enrollment).

If the student has graduated, he or she may be eligible for coverage for three months after graduation. Graduation is defined as the successful completion of studies to earn a degree/certificate, not the date of the graduation ceremony. If you do not want your dependent to be covered for the three-month period following graduation, please notify us in writing.

☐ My dependent is no longer eligible for PEBB coverage, effective _____ (month/day/year).

Last date of school enrollment _____ (month/day/year)

☐ My dependent has graduated; his or her graduation date was _____ (month/day/year).

SECTION 5: Subscriber Certification and Signature *(Required)*

Insurance coverage is determined through verification of eligibility by the Washington State Health Care Authority (HCA). I have read the eligibility requirements on the front of this form, and I declare to the best of my knowledge and belief the information provided by me on this form is true and correct and all eligibility requirements have been met. I understand I may be subject to repayment of any claims paid by my health plan or premiums paid on my behalf if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines. I understand that failure to provide accurate information or update information in accordance with PEBB rules may result in loss of coverage as of the last day of the month in which eligibility was met.

A deposit of premium does not guarantee coverage. If applicable, premiums will be refunded subject to the PEBB program's refund policy.
I understand the HCA reserves the right to verify this information at any time.

This form supersedes all forms and submissions I have previously made for PEBB coverage.

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request or by calling 360-923-2822 or online at **www.hca.wa.gov**.

Print name _____

Signature (required) _____ Date _____

Mail completed form to:
Washington State Health Care Authority
P.O. Box 42684
Olympia, WA 98504-2684

Or fax to: 360-923-2602

You must mail or hand-deliver this form if you want to terminate coverage for your dependent.